**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

FIRST CHOICE FAMILY CHIROPRACTIC
1102 N. JEFFERSON ST
DUBLIN GA 31021

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

**Respondent Name**

EMPLOYERS GENERAL INSURANCE

**Carrier's Austin Representative Box**

Box Number 44

**MFDR Tracking Number**
M4-12-2797-01

**MFDR Received Date**
MAY 1, 2012

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Code 01 – adjustors failure to forward documentation set by our office. – failure to comply with verbal agreement – proper documents provided by adjuster were sent in the order it was sent by us."

**Amount in Dispute:** $1,107.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The carrier relies upon its review and reduction of the provider's bill as reflected in its EOBs. The carrier asserts that it has paid according to applicable fee guidelines. All reductions of the disputed charges were appropriately made."

**Response Submitted by:** Flahive, Ogden & Latson, PO Drawer 201329, Austin, TX 78720

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| September 26, 20011 through February 3, 2012 | Physical Therapy Services<br>Office Visits<br>Chiropractic Services | $1,107.00 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.250 sets out the procedures for reconsideration for payment of medical bills.
3. 28 Texas Administrative Code §133.600 sets out the procedures for obtaining preauthorization.
4. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.

5. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
6. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 125 – Denial/reduction due to submission/billing error
   - RM7 – Invalid code for CMS payment-resubmit w/valid code
   - 197 – Payment adjusted for absence of percent/preauthorization
   - RVW – Reviewed, no reduction determined.
   - RG3 – Included in another billed procedure.
   - 29, RM2 – Time limit for filing claim/bill has expired.
   - B15 – Procedure/service is not paid separately.

**Issues**

1. Did the requestor submit the request for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307?
2. Did the requestor submit the bills timely?
3. Did the requestor obtain preauthorization for physical therapy?
4. Is the requestor entitled to reimbursement?

**Findings**

1. In accordance with 28 Texas Administrative Code §133.307(c)(2)(A) states that requests for medical dispute resolution (MDR) shall be filed in the form and manner prescribed by the Division. Requestors shall file two legible copies of the request with the Division. (2) The provider shall complete the required sections of the request in the form and manner prescribed by the Division. The provider shall file the request with the MDR Section by any mail service or personal delivery. The request shall include: (A)a copy of all medical bill(s), in a paper billing format using an appropriate DWC approved paper billing format, as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration in accordance with §133.250 of this chapter (relating to Reconsideration for Payment of Medical Bills). Review of the documentation submitted by both parties' shows the requestor has not submitted copies of the CMS-1500 billing form; the requestor has submitted a statement of account that is addressed to the injured employee.
2. 28 Texas Administrative Code §133.20(b)states in part, except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. In accordance with subsection (c) of the statute, the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill. A health care provider who submits a medical bill to the correct workers' compensation insurance carrier shall include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied. The medical bill submitted by the health care provider to the correct workers' compensation insurance carrier is subject to the billing, review, and dispute processes established by Chapter 133, including §133.307(c)(2)(A) - (H) of this title (relating to MDR of Fee Disputes), which establishes the generally acceptable standards for documentation. Review of the submitted documentation finds that the requestor has not submitted documentation to support that the medical bills were timely submitted to the respondent.
3. In accordance with 28 Texas Administrative Code §134.600(5)(p)Non-emergency health care requiring preauthorization includes: physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels:(A)Level I code range for Physical Medicine and Rehabilitation, but limited to: (i)Modalities, both supervised and constant attendance; (ii)Therapeutic procedures, excluding work hardening and work conditioning; (iii)Orthotics/Prosthetics Management;(iv)Other procedures, limited to the unlisted physical medicine and rehabilitation procedure code; and (B)Level II temporary code(s) for physical and occupational therapy services provided in a home setting. Review of the documentation submitted by the requestor finds the requestor attempted to obtain preauthorization for the services rendered; however, the requestor did not submit a preauthorization approval from the respondents' preauthorization company, CorVel. Therefore, preauthorization was not obtained.
4. Review of the documentation submitted by both parties finds the requestor is not due reimbursement.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

**Authorized Signature**

| | | |
|---|---|---|
| | | May 16, 2013 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO REQUEST AN APPEAL*

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.